

# Preface

*We haven't the money, so we've got to think.*

—Lord Rutherford (1871–1937)

WHEN IT COMES to facility planning trends and capital investment, I have a tendency to divide healthcare organizations into the “haves” and the “have-nots.” The haves are those well endowed and profitable healthcare organizations that maintain a continuous cycle of renewing and regenerating their facilities. Their investments in new or renovated facilities are generally well thought out and frequently visionary, even though their capital dollars are occasionally spent on oversized or inappropriate projects. The chief executive officers and board members of these organizations often take great pride in playing the role of the “master builder” and point to new “bricks and mortar” as part of their legacy. Whether their success is the result of the genius of their strategies or is simply a function of being in the right place (market) at the right time, their customers—patients, employees, and physicians—ultimately derive substantial benefit from their expenditures.

On the other hand are the have-nots. Many healthcare organizations are still in survival mode and have not been able to focus on investing strategically in the future. In 2013, nearly one-third of community hospitals had negative operating margins and one-quarter lost money overall. Moreover, two-thirds of community hospitals lost money providing care to Medicare and Medicaid patients (American Hospital Association and Avalere Health 2014). Such financial pressures make it difficult for these healthcare organizations to make critical investments in their facilities. These organizations struggle to break even in more demographically challenged markets, experience limited negotiating leverage with payers, and find that sufficient capital is hard to obtain at their current levels of performance and cash flow. They must continue to squeeze the last bit of life out of their aging facilities with inadequate capital for retooling and renewal. Their dedicated staff use their expertise and empathy to create a healing environment. While curtailing capital spending can be a useful short-term strategy to preserve liquidity, it leads

to long-term problems that are very hard to solve, including the rising age of the physical plant.

This observation is substantiated by the widening credit gap between strong and weak healthcare providers. In 2014, bond-rating downgrades for the not-for-profit healthcare sector continued to exceed upgrades. Moody's Investors Services (2015) anticipated that there would continue to be more downgrades than upgrades in 2015.

Regardless of the financial situation, perspective, and culture of healthcare organizations, very few of them have capital to spend on inappropriate or unnecessary renovation or construction projects. Moreover, planning a major renovation project, or a new healthcare facility, is a rare opportunity for an organization to rethink its current patient care delivery model, operational systems and processes, and use of technology. A major investment of dollars in healthcare facilities should result in enhanced customer service, improved operational efficiency, potential new revenue, and increased flexibility, in addition to aesthetically pleasing, better-engineered, and code-compliant buildings that are the products of architects and engineers. At the same time, new or renovated facilities being planned today must be responsive to the needs of patients, caregivers, and payers in the twenty-first century and beyond.

The focus of this book is on predesign planning—a stage of the healthcare facility planning, design, and construction process that is frequently overlooked as organizations eagerly jump from strategic (market) planning into the more glamorous phase of design, which is typically led by an enthusiastic architect. During predesign planning, the healthcare executive has the greatest opportunity to express his or her vision for the organization, influence the nature of the process (i.e., using a top-down or a bottom-up approach), and provide input relative to the future services to be provided—their size, their location, and their financial structure. Decisions made during predesign planning also have the most impact on long-term operational costs, compared to the initial cost of the bricks and mortar. Considering that buildings constructed today may be used for a half-century or more, the time spent on predesign planning provides a disproportionately large return on investment.

The overall predesign planning process remains unchanged since the first edition of *Healthcare Facility Planning* was published in 2005. Not surprisingly, the US healthcare sector is still in a crisis. Many of the changes made in the second edition are related to the dynamic healthcare environment. Healthcare reform and new financial incentives, fluctuating utilization and demand, constant demands for technology adoption and deployment, rising turf wars among specialists, an intense focus on patient safety, and aging physical plants—all of these affect how new or renovated healthcare facilities are planned, designed, financed, and built.

This book is intended as a practical guide and is based on my 30 years' experience as a predesign planning consultant, assisting healthcare executives and boards

in optimizing their facility investments and providing future flexibility. I hope that this book will help you to understand the importance of the predesign planning process and to tailor the process to the unique needs of your organization. By deploying an integrated facility planning process, understanding the trends that affect space allocation and configuration, and planning flexible facilities, you can move confidently from planning to implementation.

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## **REFERENCES**

- American Hospital Association and Avalere Health. 2014. *TrendWatch Chartbook 2014: Trends Affecting Hospitals and Health Systems*. Accessed January 13, 2016. [www.aha.org/research/reports/tw/chartbook/2014/14chartbook.pdf](http://www.aha.org/research/reports/tw/chartbook/2014/14chartbook.pdf).
- Moody's Investors Services. 2015. "Public Finance Upgrades Outperform in Fourth Quarter; Downgrades Prevail in 2014." Published February 10. [www.moodys.com/research/Moodys-Public-finance-upgrades-outperform-in-fourth-quarter-downgrades-prevail--PR\\_318273](http://www.moodys.com/research/Moodys-Public-finance-upgrades-outperform-in-fourth-quarter-downgrades-prevail--PR_318273).